CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Clark Archer, ER Physician
TriStar StoneCrest
200 StoneCrest Boulevard
Smyrna, TN 37167

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Archer:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Dr. Archer and his failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

EXHIBIT
1A

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookian

RE: John Ruffino

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will receive a copy of this form after I sign it.

SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

SECTION C: SIGNATURES

I have read the above and authorize the disclosure of the protected medical and health information as stated. Moreover, I acknowledge and hereby consent that the released information may contain alcohol, drug, psychiatric, HIV testing, HIV results, or AIDS information.

Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
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Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
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Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	**State** TN	**Zip** 37167

This authorization will expire on the following (fill in the Date or the Event but ~~not both~~)
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
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Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 2910 South Church Street Suite B Murfreesboro, TN 37127	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:** **Event:** Filing of Lawsuit			
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167

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Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

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Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	**Recipient's Name:** Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167

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December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Clark Archer
2910 South Church Street, Suite B .
Murfreesboro, TN 37127

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Archer:

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The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

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The name and address of the attorney sending this notice is:

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45 Music Square West
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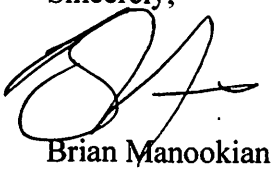
Sincerely,



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Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

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Provider's Name: Dr. Deka Efobi	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 2910 South Church Street		
	Address 2:		
	City Murfreesboro	**State** TN	**Zip** 37127

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Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

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Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 2910 South Church Street		
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Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** 2910 South Church Street		
	Address 2:		
	City Murfreesboro	**State** TN	**Zip** 37127
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:** **Event:** Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient** (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 2910 South Church Street		
	Address 2:		
	City Murfreesboro	State TN	Zip 37127
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 2910 South Church Street Suite B Murfreesboro, TN 37127	**Address 1:** 2910 South Church Street		
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 2910 South Church Street		
	Address 2:		
	City Murfreesboro	**State** TN	**Zip** 37127
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:**	**Event:** Filing of Lawsuit		
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HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	**Recipient's Name:** Dr. Clark Archer		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	**Address 1:** 2910 South Church Street		
	Address 2:		
	City Murfreesboro	State TN	Zip 37127
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Deka Efobi
305 West Main Street
Lebanon, TN 37087-3545

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Efobi:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Dr. Efobi and her failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

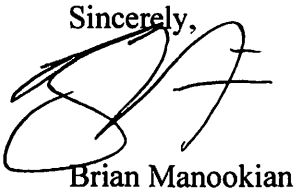
The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,



Brian Manookian

RE: John Ruffino

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 305 West Main Street		
	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the following (fill in the Date or the Event but not both) Date:	Event: Filing of Lawsuit		
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Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 305 West Main Street		
	Address 2:		
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Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** 305 West Main Street		
	Address 2:		
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Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 305 West Main Street		
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Provider's Name: Dr. Clark Archer	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 2910 South Church Street Suite B Murfreesboro, TN 37127	**Address 1:** 305 West Main Street		
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Provider's Name: StoneCrest Medical Center	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 305 West Main Street		
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I have read the above and authorize the disclosure of the protected medical and health information as stated. Moreover, I acknowledge and hereby consent that the released information may contain alcohol, drug, psychiatric, HIV testing, HIV results, or AIDS information.

Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	**Recipient's Name:** Dr. Deka Efobi		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	**Address 1:** 305 West Main Street		
	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:** **Event:** Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Neurology Clinic & Associates
P.O. Box 414
Brentwood, TN 37024-0414

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Neurology Clinic & Associates:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Neurology Clinic & Associates and its failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

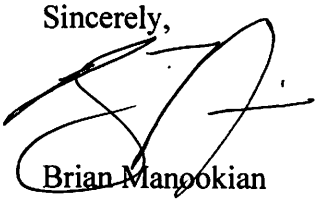
The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,



Brian Manookian

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	**State** TN	**Zip** 37024
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:**	**Event:** Filing of Lawsuit		
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
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SECTION C: SIGNATURES

I have read the above and authorize the disclosure of the protected medical and health information as stated. Moreover, I acknowledge and hereby consent that the released information may contain alcohol, drug, psychiatric, HIV testing, HIV results, or AIDS information.

Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 2910 South Church Street Suite B Murfreesboro, TN 37127	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** P.O. Box 414		
	Address 2:		
	City Brentwood	**State** TN	**Zip** 37024
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:**	**Event:** Filing of Lawsuit		
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	Recipient's Name: Neurology Clinic & Associates		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	Address 1: P.O. Box 414		
	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both) Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

StoneCrest Medical Center
c/o CT Corporation System
800 South Gay Street, #2021
Knoxville, TN 37929-9710

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear StoneCrest Medical Center:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of StoneCrest Medical Center and its failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

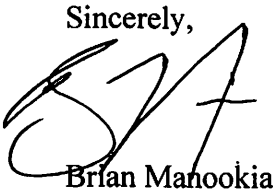
The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,



Brian Manookian

RE: John Ruffino

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 800 South Gay Street		
	Address 2: Suite 2021		
	City Knoxville	**State** TN	**Zip** 37929

This authorization will expire on the following (fill in the Date or the Event but not both)
Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	**Date:** 3-18-16
Print Name of Guardian / Representative (if applicable):	**Relationship to Patient (if applicable):**

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 800 South Gay Street		
	Address 2: Suite 2021		
	City Knoxville	State TN	Zip 37929

This authorization will expire on the following (fill in the Date or the Event but not both)
Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

I understand that:

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HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

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Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** 800 South Gay Street		
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	City Knoxville	**State** TN	**Zip** 37929
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 800 South Gay Street		
	Address 2: Suite 2021		
	City Knoxville	**State** TN	**Zip** 37929
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS

Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name: Dr. Clark Archer	Recipient's Name: StoneCrest Medical Center c/o CT Corporation System	
Provider's Address: 2910 South Church Street Suite B Murfreesboro, TN 37127	Address 1: 800 South Gay Street	
	Address 2: Suite 2021	
	City Knoxville	State TN Zip 37929

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Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 800 South Gay Street		
	Address 2: Suite 2021		
	City Knoxville	**State** TN	**Zip** 37929
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Provider's Name: StoneCrest Medical Center c/o CT Corporation System	**Recipient's Name:** StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	**Address 1:** 800 South Gay Street		
	Address 2: Suite 2021		
	City Knoxville	**State** TN	**Zip** 37929
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CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

StoneCrest Medical Center
200 StoneCrest Boulevard
Smyrna, TN 37167

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear StoneCrest Medical Center:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of StoneCrest Medical Center and its failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

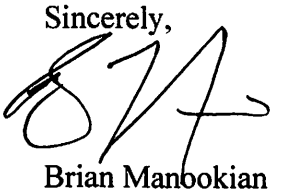
The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,



Brian Manookian

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** StoneCrest Medical Center		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	**State** TN	**Zip** 37167
This authorization will expire on the following (fill in the Date or the Event but not both) **Date:**	**Event:** Filing of Lawsuit		
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
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Print Name of Guardian / Representative (if applicable):	**Relationship to Patient** (if applicable):

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Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 200 StoneCrest Boulevard		
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Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** StoneCrest Medical Center		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 200 StoneCrest Boulevard		
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	City Smyrna	State TN	Zip 37167
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Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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SECTION C: SIGNATURES

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	**Recipient's Name:** StoneCrest Medical Center		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167

This authorization will expire on the following (fill in the Date or the Event but not both)
Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	**Recipient's Name:** StoneCrest Medical Center		
Provider's Address 800 South Gay Street, #2021 Knoxville, TN 37929-9710	**Address 1:** 200 StoneCrest Boulevard		
	Address 2:		
	City Smyrna	State TN	Zip 37167
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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

CUMMINGS MANOOKIAN

BRIAN CUMMINGS
Licensed to practice in
TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Neurology Clinic & Associates
305 West Main Street
Lebanon, TN 37087-3545

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Neurology Clinic & Associates:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Neurology Clinic & Associates and its failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino
06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino
1206 South Sixth Street
Mayfield, KY 42066

45 Music Square West
Nashville, TN 37203
T 615.266.3333
F 615.266.0250

Pauahi Tower
1003 Bishop St.
Suite 2710
Honolulu, HI 96813
T 808.444.4800
F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian
45 Music Square West
Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookian

RE: John Ruffino

LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE PURSUANT TO TENN. CODE ANN. § 29-26-121(a)

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 305 West Main Street		
	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the following (fill in the Date or the Event but not both) Date:	Event: Filing of Lawsuit		
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			
Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates			

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Signature of Patient / Plan Member / Guardian / Representative: John Ruffino	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	**Address 1:** 305 West Main Street		
	Address 2:		
	City Lebanon	State TN	Zip 37087

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Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address P.O. Box 414 Brentwood, TN 37024-0414	**Address 1:** 305 West Main Street		
	Address 2:		
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SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer TriStar StoneCrest	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 200 StoneCrest Boulevard Smyrna, TN 37167	**Address 1:** 305 West Main Street		
	Address 2:		
	City Lebanon	State TN	Zip 37087

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Patient Name: JOHN RUFFINO	**Date of Birth:** 06-12-1959	**Social Security No:** XXX-XX-7251	
Provider's Name: Dr. Clark Archer	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 2910 South Church Street Suite B Murfreesboro, TN 37127	**Address 1:** 305 West Main Street		
	Address 2:		
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Provider's Name: StoneCrest Medical Center	**Recipient's Name:** Neurology Clinic & Associates		
Provider's Address 200 StoneCrest Bouelvard Smyrna, TN 37167	**Address 1:** 305 West Main Street		
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